Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VA Black Hills HCS (VAMC Fort Meade - 568 and VAMC Hot Springs - 568A4)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 120

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 120 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	86	10
Transitional Housing Beds	48	12
Permanent Housing Beds	25	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Using all transitional housing and halfway houses. New TR house on VAMC at Hot Springs (11 beds). PTSD TR house at Pine Ridge. Ten additional veterans beds at RC Mission.
Long-term, permanent housing	Ongoing collaboration with local housing organizations.
Services for emotional or psychiatric problems	Increased collaboration with RC mission veterans coordinator linking homeless veterans with medical/mental health services with the Rapid City VA clinic.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **19 Non-VA staff Participants: 94.4%**
Homeless/Formerly Homeless: **36.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.94	6.0%	3.47
Food	4.22	6.0%	3.80
Clothing	4.00	6.0%	3.61
Emergency (immediate) shelter	4.42	18.0%	3.33
Halfway house or transitional living facility	2.61	47.0%	3.07
Long-term, permanent housing	2.28	41.0%	2.49
Detoxification from substances	3.56	6.0%	3.41
Treatment for substance abuse	3.72	6.0%	3.55
Services for emotional or psychiatric problems	3.6	18.0%	3.46
Treatment for dual diagnosis	3.2	12.0%	3.30
Family counseling	3.44	6.0%	2.99
Medical services	4.00	6.0%	3.78
Women's health care	4.00	.0%	3.23
Help with medication	4.41	12.0%	3.46
Drop-in center or day program	3.13	.0%	2.98
AIDS/HIV testing/counseling	3.56	.0%	3.51
TB testing	3.88	.0%	3.71
TB treatment	3.69	.0%	3.57
Hepatitis C testing	3.38	6.0%	3.63
Dental care	2.76	6.0%	2.59
Eye care	2.94	.0%	2.88
Glasses	2.94	.0%	2.88
VA disability/pension	3.33	.0%	3.40
Welfare payments	2.94	.0%	3.03
SSI/SSD process	3.06	6.0%	3.10
Guardianship (financial)	3.13	12.0%	2.85
Help managing money	3.29	6.0%	2.87
Job training	2.82	6.0%	3.02
Help with finding a job or getting employment	3.12	12.0%	3.14
Help getting needed documents or identification	3.71	6.0%	3.28
Help with transportation	3.67	12.0%	3.02
Education	3.18	.0%	3.00
Child care	2.47	12.0%	2.45
Legal assistance	2.88	6.0%	2.71
Discharge upgrade	3.29	.0%	3.00
Spiritual	3.78	6.0%	3.36
Re-entry services for incarcerated veterans	2.88	12.0%	2.72
Elder Healthcare	2.76	6.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.63
Co-location of Services - Services from the VA and your agency provided in one location.	2.07
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.43
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.93
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.25
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.87
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.50
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.71
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.57
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.13

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.88
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.73

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CHALENG 2005 Survey: VAH&ROC Sioux Falls, SD - 438

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 45

2. Estimated Number of Veterans who are Chronically Homeless: 11

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 45 (estimated number of homeless veterans in service area) **x chronically homeless rate (25 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	50
Transitional Housing Beds	305	30
Permanent Housing Beds	0	30

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Hire VA Homeless Coordinator for Sioux Falls. That person will work with community agencies to explore options/programs needed for local homeless veterans.
Immediate shelter	Hire VA Homeless Coordinator for Sioux Falls. That person will work with community agencies to explore options/programs needed for local homeless veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **2 Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.50	.0%	3.47
Food	4.50	.0%	3.80
Clothing	4.00	.0%	3.61
Emergency (immediate) shelter	2.50	.0%	3.33
Halfway house or transitional living facility	2.00	.0%	3.07
Long-term, permanent housing	1.00	100.0%	2.49
Detoxification from substances	4.00	.0%	3.41
Treatment for substance abuse	4.00	.0%	3.55
Services for emotional or psychiatric problems	4.0	.0%	3.46
Treatment for dual diagnosis	4.0	.0%	3.30
Family counseling	3.50	.0%	2.99
Medical services	4.50	.0%	3.78
Women's health care	3.50	.0%	3.23
Help with medication	2.00	.0%	3.46
Drop-in center or day program	3.00	50.0%	2.98
AIDS/HIV testing/counseling	1.50	.0%	3.51
TB testing	4.00	.0%	3.71
TB treatment	4.00	.0%	3.57
Hepatitis C testing	4.00	.0%	3.63
Dental care	3.00	.0%	2.59
Eye care	3.00	.0%	2.88
Glasses	3.00	.0%	2.88
VA disability/pension	4.00	.0%	3.40
Welfare payments	1.50	50.0%	3.03
SSI/SSD process	2.50	.0%	3.10
Guardianship (financial)	2.00	.0%	2.85
Help managing money	2.00	.0%	2.87
Job training	2.00	50.0%	3.02
Help with finding a job or getting employment	2.00	.0%	3.14
Help getting needed documents or identification	2.50	.0%	3.28
Help with transportation	2.50	50.0%	3.02
Education	2.50	.0%	3.00
Child care	2.00	.0%	2.45
Legal assistance	1.50	.0%	2.71
Discharge upgrade	2.50	.0%	3.00
Spiritual	2.50	.0%	3.36
Re-entry services for incarcerated veterans	1.50	.0%	2.72
Elder Healthcare	2.50	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.50
Co-location of Services - Services from the VA and your agency provided in one location.	1.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.00
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.50
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.50

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CHALENG 2005 Survey: VAM&ROC Fargo, ND - 437

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Estimated Number of Veterans who are Chronically Homeless: 400

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1000 (estimated number of homeless veterans in service area) **x chronically homeless rate (40 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	679	117
Transitional Housing Beds	282	0
Permanent Housing Beds	262	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue encouragement for eligible community activities to apply for available funding. Increase collaboration with local housing authorities for increased scattered site/Shelter Plus Care and Section 8 vouchers.
Transitional living facility or halfway house	Expand transitional living opportunities in catchment area with old/new treatment facilities. Continue support/involvement with Centre, Inc.; Fargo, ND on their approved 48-bed Grant and Per Diem project.
Immediate shelter	Continue ongoing collaboration/encouragement for existing shelters to expand capacity. Support exploration for opening shelters in Jamestown, ND, Grand Rapids and Red Lake, MN.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **65** **Non-VA staff Participants: 72.6%**
Homeless/Formerly Homeless: **1.5%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.64	2.0%	3.47
Food	3.94	3.0%	3.80
Clothing	3.77	.0%	3.61
Emergency (immediate) shelter	3.40	28.0%	3.33
Halfway house or transitional living facility	2.82	30.0%	3.07
Long-term, permanent housing	2.69	45.0%	2.49
Detoxification from substances	3.47	5.0%	3.41
Treatment for substance abuse	3.39	17.0%	3.55
Services for emotional or psychiatric problems	3.3	17.0%	3.46
Treatment for dual diagnosis	3.3	15.0%	3.30
Family counseling	3.09	2.0%	2.99
Medical services	3.80	7.0%	3.78
Women's health care	3.48	2.0%	3.23
Help with medication	3.36	2.0%	3.46
Drop-in center or day program	2.60	10.0%	2.98
AIDS/HIV testing/counseling	3.53	2.0%	3.51
TB testing	3.56	.0%	3.71
TB treatment	3.36	.0%	3.57
Hepatitis C testing	3.58	.0%	3.63
Dental care	2.43	23.0%	2.59
Eye care	2.81	10.0%	2.88
Glasses	2.78	8.0%	2.88
VA disability/pension	3.73	8.0%	3.40
Welfare payments	3.44	.0%	3.03
SSI/SSD process	3.38	2.0%	3.10
Guardianship (financial)	3.15	5.0%	2.85
Help managing money	3.02	8.0%	2.87
Job training	3.25	8.0%	3.02
Help with finding a job or getting employment	3.41	7.0%	3.14
Help getting needed documents or identification	3.60	3.0%	3.28
Help with transportation	3.26	7.0%	3.02
Education	3.08	2.0%	3.00
Child care	2.60	10.0%	2.45
Legal assistance	2.93	2.0%	2.71
Discharge upgrade	3.36	.0%	3.00
Spiritual	3.52	3.0%	3.36
Re-entry services for incarcerated veterans	2.75	3.0%	2.72
Elder Healthcare	3.46	3.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.58
Co-location of Services - Services from the VA and your agency provided in one location.	1.80
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.71
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.17
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.33
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.15
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.80
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.36
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.55
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.49
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.56
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.51

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.57
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.88

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CHALENG 2005 Survey: VAMC Minneapolis, MN - 618, and Superior, WI

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 423

2. Estimated Number of Veterans who are Chronically Homeless: 68

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 423 (estimated number of homeless veterans in service area) **x chronically homeless rate (16 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	940	140
Transitional Housing Beds	150	20
Permanent Housing Beds	212	200

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Ongoing support for 220 bed SRO on VA property. Attend St. Paul Area Coalition for Homeless and provide support for housing projects. HCHV provides assistance for homeless veterans on how to access and apply for long-term housing.
Transitional living facility or halfway house	HCHV staff work with homeless veterans to make application and promote care and treatment that will increase likely successful admission.
Transportation	Refer to community resources and as feasible determine if used and need met. Develop HCHV policy for issuance of tokens. Develop policy for HCHV transport of veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **22** **Non-VA staff Participants: 81.8%**
Homeless/Formerly Homeless: **4.5%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.86	.0%	3.47
Food	4.14	5.0%	3.80
Clothing	4.00	.0%	3.61
Emergency (immediate) shelter	3.19	11.0%	3.33
Halfway house or transitional living facility	2.76	26.0%	3.07
Long-term, permanent housing	1.90	80.0%	2.49
Detoxification from substances	4.00	.0%	3.41
Treatment for substance abuse	4.19	.0%	3.55
Services for emotional or psychiatric problems	3.7	11.0%	3.46
Treatment for dual diagnosis	3.2	11.0%	3.30
Family counseling	2.74	11.0%	2.99
Medical services	4.29	.0%	3.78
Women's health care	3.68	.0%	3.23
Help with medication	3.76	.0%	3.46
Drop-in center or day program	3.21	11.0%	2.98
AIDS/HIV testing/counseling	4.11	.0%	3.51
TB testing	4.26	.0%	3.71
TB treatment	4.17	.0%	3.57
Hepatitis C testing	4.11	.0%	3.63
Dental care	2.65	11.0%	2.59
Eye care	3.15	.0%	2.88
Glasses	3.10	.0%	2.88
VA disability/pension	3.95	.0%	3.40
Welfare payments	3.32	.0%	3.03
SSI/SSD process	3.35	.0%	3.10
Guardianship (financial)	2.85	11.0%	2.85
Help managing money	2.95	11.0%	2.87
Job training	3.14	5.0%	3.02
Help with finding a job or getting employment	3.10	21.0%	3.14
Help getting needed documents or identification	3.71	.0%	3.28
Help with transportation	2.71	21.0%	3.02
Education	2.90	5.0%	3.00
Child care	2.58	5.0%	2.45
Legal assistance	2.95	11.0%	2.71
Discharge upgrade	3.37	5.0%	3.00
Spiritual	3.65	.0%	3.36
Re-entry services for incarcerated veterans	2.29	16.0%	2.72
Elder Healthcare	3.33	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.88
Co-location of Services - Services from the VA and your agency provided in one location.	2.59
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.24
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.06
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.69
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.56
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.19
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.69
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.56
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.63
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.94

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.67
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.94

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC St. Cloud, MN - 656

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 70

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 70 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	77	45
Transitional Housing Beds	248	30
Permanent Housing Beds	250	60

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Sixty units currently under construction and will be filled with 50% veterans. Support additional 32 units planned by local nonprofit. Support local HRA in construction of low-income, affordable housing.
Dental care	Work toward agreement with local dentists to serve homeless veterans.
Re-entry services for incarcerated veterans	Work with Stearne County Re-Entry Assessment Program to identify homeless veterans being released from jail. Assess number and needs of veterans being paroled from prisons.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **18** **Non-VA staff Participants: 94.4%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.13	6.0%	3.47
Food	3.71	12.0%	3.80
Clothing	3.59	6.0%	3.61
Emergency (immediate) shelter	2.82	13.0%	3.33
Halfway house or transitional living facility	2.41	31.0%	3.07
Long-term, permanent housing	1.65	63.0%	2.49
Detoxification from substances	3.24	.0%	3.41
Treatment for substance abuse	3.65	.0%	3.55
Services for emotional or psychiatric problems	3.7	6.0%	3.46
Treatment for dual diagnosis	3.5	6.0%	3.30
Family counseling	3.06	6.0%	2.99
Medical services	3.71	6.0%	3.78
Women's health care	3.24	.0%	3.23
Help with medication	2.94	6.0%	3.46
Drop-in center or day program	2.67	.0%	2.98
AIDS/HIV testing/counseling	3.12	.0%	3.51
TB testing	3.24	.0%	3.71
TB treatment	3.18	.0%	3.57
Hepatitis C testing	3.18	.0%	3.63
Dental care	1.88	31.0%	2.59
Eye care	2.29	13.0%	2.88
Glasses	2.41	.0%	2.88
VA disability/pension	3.59	6.0%	3.40
Welfare payments	3.35	.0%	3.03
SSI/SSD process	3.00	.0%	3.10
Guardianship (financial)	2.65	.0%	2.85
Help managing money	2.44	18.0%	2.87
Job training	3.00	19.0%	3.02
Help with finding a job or getting employment	2.78	6.0%	3.14
Help getting needed documents or identification	2.82	.0%	3.28
Help with transportation	2.65	6.0%	3.02
Education	2.65	6.0%	3.00
Child care	2.06	19.0%	2.45
Legal assistance	2.82	.0%	2.71
Discharge upgrade	3.31	.0%	3.00
Spiritual	3.35	.0%	3.36
Re-entry services for incarcerated veterans	1.94	19.0%	2.72
Elder Healthcare	3.12	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.12
Co-location of Services - Services from the VA and your agency provided in one location.	2.06
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.35
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.31
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.25
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.81
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.19
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.63
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.38
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.60

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.71
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.65

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA Central Iowa HCS (VAMC Knoxville - 555A4)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 15

2. Estimated Number of Veterans who are Chronically Homeless: 5

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 15 (estimated number of homeless veterans in service area) **x chronically homeless rate (32 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	20	0
Transitional Housing Beds	108	0
Permanent Housing Beds	10	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	In approximately 6 months, there will be a new GPD program in Des Moines that will serve 23 veterans. Continue to work with community agencies to encourage funding for transitional housing.
Dental care	Refer homeless to dental colleges. Attend community agency fairs to identify dental service providers.
Help finding a job or getting employment	Continue making referrals to Work Force Development, HVRP, Voc Rehabilitation and CWT.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **8** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.75	14.0%	3.47
Food	4.38	.0%	3.80
Clothing	4.13	.0%	3.61
Emergency (immediate) shelter	3.75	38.0%	3.33
Halfway house or transitional living facility	2.25	43.0%	3.07
Long-term, permanent housing	2.25	14.0%	2.49
Detoxification from substances	3.00	14.0%	3.41
Treatment for substance abuse	3.00	14.0%	3.55
Services for emotional or psychiatric problems	3.0	.0%	3.46
Treatment for dual diagnosis	2.8	29.0%	3.30
Family counseling	3.50	.0%	2.99
Medical services	4.00	.0%	3.78
Women's health care	4.00	.0%	3.23
Help with medication	4.14	.0%	3.46
Drop-in center or day program	2.57	14.0%	2.98
AIDS/HIV testing/counseling	3.71	.0%	3.51
TB testing	3.86	.0%	3.71
TB treatment	3.00	.0%	3.57
Hepatitis C testing	4.00	.0%	3.63
Dental care	2.14	29.0%	2.59
Eye care	3.86	.0%	2.88
Glasses	3.29	.0%	2.88
VA disability/pension	4.29	13.0%	3.40
Welfare payments	4.00	.0%	3.03
SSI/SSD process	3.14	.0%	3.10
Guardianship (financial)	2.43	.0%	2.85
Help managing money	2.71	14.0%	2.87
Job training	3.13	14.0%	3.02
Help with finding a job or getting employment	3.13	43.0%	3.14
Help getting needed documents or identification	4.00	.0%	3.28
Help with transportation	4.00	14.0%	3.02
Education	2.86	.0%	3.00
Child care	2.00	.0%	2.45
Legal assistance	2.71	14.0%	2.71
Discharge upgrade	3.71	.0%	3.00
Spiritual	3.43	.0%	3.36
Re-entry services for incarcerated veterans	3.33	.0%	2.72
Elder Healthcare	4.00	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.29
Co-location of Services - Services from the VA and your agency provided in one location.	1.86
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.14
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.57
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.43
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.43
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.14
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.29
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.43
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.29
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.14

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.38
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA Central Iowa HCS (VAMC Des Moines - 555)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 100

2. Estimated Number of Veterans who are Chronically Homeless: 32

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 100 (estimated number of homeless veterans in service area) **x chronically homeless rate (32 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	95	100
Transitional Housing Beds	259	100
Permanent Housing Beds	125	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Re-entry services for incarcerated veterans	Work with local providers and parole officers to free up beds in the community.
Immediate shelter	Work with community providers and city officials to free up beds for emergency shelter.
Treatment for substance abuse	Work with providers at the VAMC to have access to more domiciliary beds here at VAMC

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **16** **Non-VA staff Participants: 81.3%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.86	.0%	3.47
Food	3.71	8.0%	3.80
Clothing	3.77	.0%	3.61
Emergency (immediate) shelter	3.00	33.0%	3.33
Halfway house or transitional living facility	2.36	33.0%	3.07
Long-term, permanent housing	2.20	46.0%	2.49
Detoxification from substances	2.86	8.0%	3.41
Treatment for substance abuse	2.93	17.0%	3.55
Services for emotional or psychiatric problems	2.8	8.0%	3.46
Treatment for dual diagnosis	2.6	.0%	3.30
Family counseling	2.71	8.0%	2.99
Medical services	3.29	.0%	3.78
Women's health care	2.93	.0%	3.23
Help with medication	2.79	8.0%	3.46
Drop-in center or day program	2.79	.0%	2.98
AIDS/HIV testing/counseling	3.29	.0%	3.51
TB testing	3.64	.0%	3.71
TB treatment	3.50	.0%	3.57
Hepatitis C testing	3.54	.0%	3.63
Dental care	2.31	17.0%	2.59
Eye care	2.54	.0%	2.88
Glasses	2.77	.0%	2.88
VA disability/pension	3.09	.0%	3.40
Welfare payments	2.82	.0%	3.03
SSI/SSD process	2.69	.0%	3.10
Guardianship (financial)	2.77	.0%	2.85
Help managing money	2.54	.0%	2.87
Job training	2.62	8.0%	3.02
Help with finding a job or getting employment	2.54	25.0%	3.14
Help getting needed documents or identification	2.85	17.0%	3.28
Help with transportation	2.31	25.0%	3.02
Education	2.77	8.0%	3.00
Child care	2.42	.0%	2.45
Legal assistance	2.46	8.0%	2.71
Discharge upgrade	2.73	.0%	3.00
Spiritual	2.67	8.0%	3.36
Re-entry services for incarcerated veterans	2.08	17.0%	2.72
Elder Healthcare	2.46	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.09
Co-location of Services - Services from the VA and your agency provided in one location.	1.73
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.64
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.55
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.36
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.64
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.40
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.82
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.91
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.18
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.30
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.55

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.89
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.78

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA HCS (VAMC Grand Island - 597A4 and VAMC Lincoln - 597)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 135

2. Estimated Number of Veterans who are Chronically Homeless: 32

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 135 (estimated number of homeless veterans in service area) **x chronically homeless rate (24 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	541	50
Transitional Housing Beds	100	50
Permanent Housing Beds	105	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Encouraged participation in HUD Homeless Housing Voucher Committee among human service agencies.
Treatment for dual diagnosis	This area needs additional resources .
Help finding a job or getting employment	Increase awareness among service providers for employment services offered by Nebraska Workforce Development, State of Nebraska Vocational Rehab, VA Voc Rehab, and temporary employment agencies.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **14** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.91	.0%	3.47
Food	4.09	9.0%	3.80
Clothing	3.82	18.0%	3.61
Emergency (immediate) shelter	3.54	27.0%	3.33
Halfway house or transitional living facility	2.83	27.0%	3.07
Long-term, permanent housing	2.92	36.0%	2.49
Detoxification from substances	3.33	18.0%	3.41
Treatment for substance abuse	3.73	.0%	3.55
Services for emotional or psychiatric problems	3.4	8.0%	3.46
Treatment for dual diagnosis	3.2	33.0%	3.30
Family counseling	3.25	9.0%	2.99
Medical services	3.92	9.0%	3.78
Women's health care	3.73	.0%	3.23
Help with medication	3.45	.0%	3.46
Drop-in center or day program	2.50	18.0%	2.98
AIDS/HIV testing/counseling	4.15	.0%	3.51
TB testing	4.15	.0%	3.71
TB treatment	4.15	.0%	3.57
Hepatitis C testing	4.25	.0%	3.63
Dental care	4.08	.0%	2.59
Eye care	4.23	.0%	2.88
Glasses	4.23	.0%	2.88
VA disability/pension	3.92	.0%	3.40
Welfare payments	3.92	.0%	3.03
SSI/SSD process	3.58	9.0%	3.10
Guardianship (financial)	3.45	.0%	2.85
Help managing money	3.64	.0%	2.87
Job training	3.77	9.0%	3.02
Help with finding a job or getting employment	4.00	27.0%	3.14
Help getting needed documents or identification	3.77	.0%	3.28
Help with transportation	3.71	18.0%	3.02
Education	3.62	9.0%	3.00
Child care	3.30	.0%	2.45
Legal assistance	3.64	.0%	2.71
Discharge upgrade	3.64	.0%	3.00
Spiritual	3.40	.0%	3.36
Re-entry services for incarcerated veterans	3.20	27.0%	2.72
Elder Healthcare	4.00	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.79
Co-location of Services - Services from the VA and your agency provided in one location.	1.64
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.31
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.85
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.31
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.31
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.15
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.77
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.69
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.50
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.58
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.54

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.67

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VA HCS (VAMC Omaha - 636)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 325

2. Estimated Number of Veterans who are Chronically Homeless: 88

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 325 (estimated number of homeless veterans in service area) **x chronically homeless rate (27 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds		
Transitional Housing Beds		
Permanent Housing Beds		

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: .

3. CHALENG Point of Contact Action Plan for FY 2005

	(no plan submitted this year)
	(no plan submitted this year)
	(no plan submitted this year)

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **Non-VA staff Participants: .0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene		%	3.47
Food		%	3.80
Clothing		%	3.61
Emergency (immediate) shelter		%	3.33
Halfway house or transitional living facility		%	3.07
Long-term, permanent housing		%	2.49
Detoxification from substances		%	3.41
Treatment for substance abuse		%	3.55
Services for emotional or psychiatric problems		%	3.46
Treatment for dual diagnosis		%	3.30
Family counseling		%	2.99
Medical services		%	3.78
Women's health care		%	3.23
Help with medication		%	3.46
Drop-in center or day program		%	2.98
AIDS/HIV testing/counseling		%	3.51
TB testing		%	3.71
TB treatment		%	3.57
Hepatitis C testing		%	3.63
Dental care		%	2.59
Eye care		%	2.88
Glasses		%	2.88
VA disability/pension		%	3.40
Welfare payments		%	3.03
SSI/SSD process		%	3.10
Guardianship (financial)		%	2.85
Help managing money		%	2.87
Job training		%	3.02
Help with finding a job or getting employment		%	3.14
Help getting needed documents or identification		%	3.28
Help with transportation		%	3.02
Education		%	3.00
Child care		%	2.45
Legal assistance		%	2.71
Discharge upgrade		%	3.00
Spiritual		%	3.36
Re-entry services for incarcerated veterans		%	2.72
Elder Healthcare		%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	
Co-location of Services - Services from the VA and your agency provided in one location.	
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Iowa City, IA - 584

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 500

2. Estimated Number of Veterans who are Chronically Homeless: 65

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 500 (estimated number of homeless veterans in service area) **x chronically homeless rate (13 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	349	50
Transitional Housing Beds	218	100
Permanent Housing Beds	587	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 15

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Plans to establish a fund for deposit assistance: CDBG, STAR. GPD applications to any agency needing construction money. Increase partnerships with local landlords and HUD.
Dental care	Referral of eligible veterans to VAMC for treatment. Grant research for local CHC that provides dental. Possible voucher system with local dentist. Possible partnership with University of Iowa Dental School for screening or treatment.
Immediate shelter	Grant and Per Diem approved . Consistency across shelters with rules and deadlines. Increase in beds for women and families. Need clinical staff onsite.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **23** **Non-VA staff Participants: 95.5%**
Homeless/Formerly Homeless: **4.3%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.76	.0%	3.47
Food	4.19	.0%	3.80
Clothing	4.19	6.0%	3.61
Emergency (immediate) shelter	3.70	12.0%	3.33
Halfway house or transitional living facility	3.30	18.0%	3.07
Long-term, permanent housing	3.14	12.0%	2.49
Detoxification from substances	3.60	.0%	3.41
Treatment for substance abuse	3.81	12.0%	3.55
Services for emotional or psychiatric problems	3.8	12.0%	3.46
Treatment for dual diagnosis	3.6	.0%	3.30
Family counseling	3.76	.0%	2.99
Medical services	4.14	12.0%	3.78
Women's health care	3.65	6.0%	3.23
Help with medication	3.55	6.0%	3.46
Drop-in center or day program	2.80	12.0%	2.98
AIDS/HIV testing/counseling	3.53	6.0%	3.51
TB testing	3.68	.0%	3.71
TB treatment	3.58	.0%	3.57
Hepatitis C testing	3.55	.0%	3.63
Dental care	2.65	24.0%	2.59
Eye care	3.25	12.0%	2.88
Glasses	3.35	12.0%	2.88
VA disability/pension	3.90	18.0%	3.40
Welfare payments	3.59	6.0%	3.03
SSI/SSD process	3.00	6.0%	3.10
Guardianship (financial)	3.05	.0%	2.85
Help managing money	3.00	6.0%	2.87
Job training	3.32	12.0%	3.02
Help with finding a job or getting employment	3.76	24.0%	3.14
Help getting needed documents or identification	3.52	12.0%	3.28
Help with transportation	3.29	6.0%	3.02
Education	3.25	6.0%	3.00
Child care	2.63	.0%	2.45
Legal assistance	2.95	18.0%	2.71
Discharge upgrade	3.20	12.0%	3.00
Spiritual	3.60	6.0%	3.36
Re-entry services for incarcerated veterans	3.11	12.0%	2.72
Elder Healthcare	3.26	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.84
Co-location of Services - Services from the VA and your agency provided in one location.	2.28
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.06
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.28
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.59
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.53
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.12
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.71
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.50
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.53

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.11
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.84